

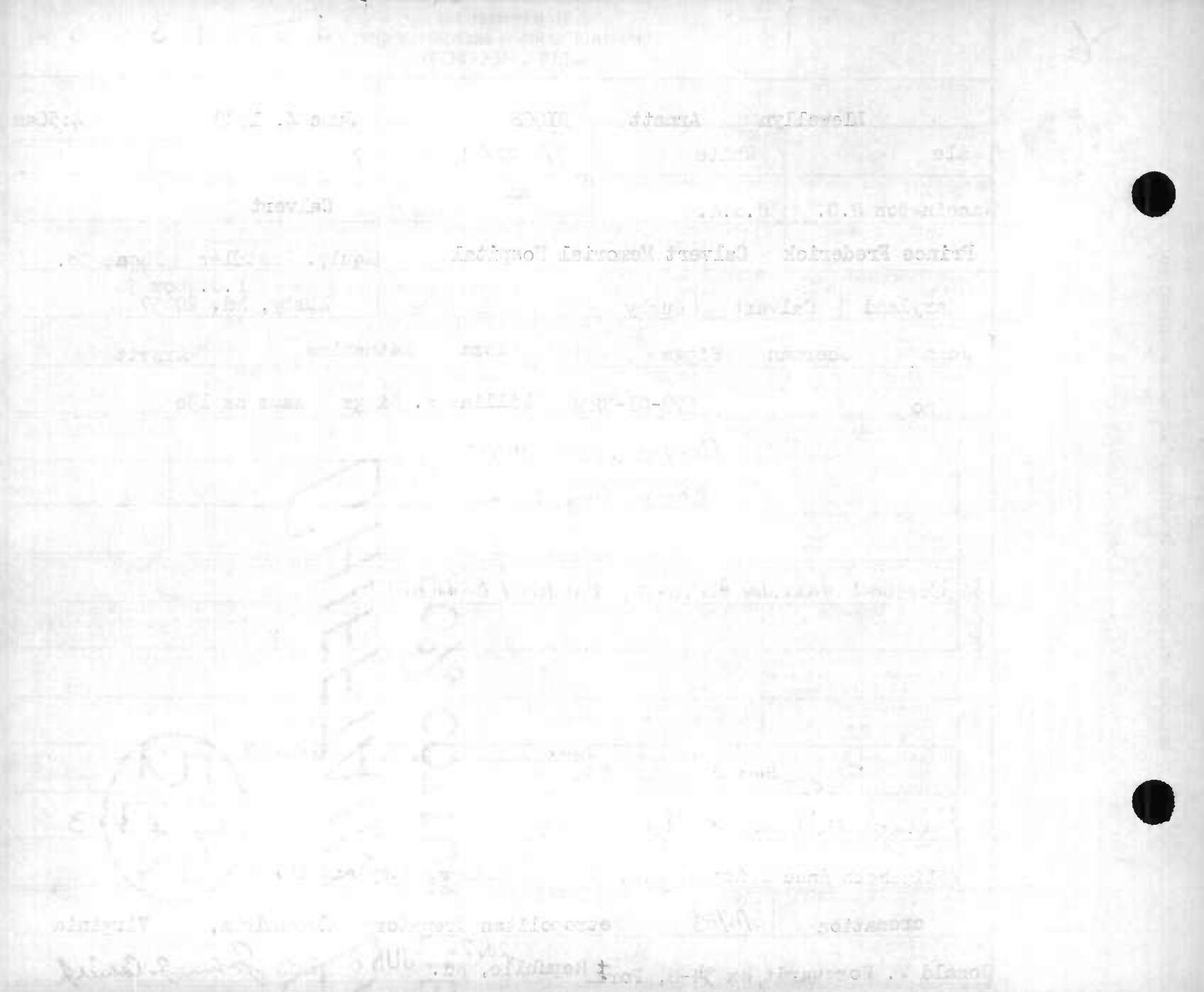
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR					8 3 1 6 0 6 4 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
Llewellyn Arnett BIGGS					June 4, 1983					1:50 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 77 <sup>Y</sup> 27 <sup>D</sup> 1905 <sup>YR</sup>		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.								
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Equip. Installer		12b. KIND OF BUSINESS OR INDUSTRY Phone Co.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 36 Lusby, Md. 20657		
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Lusby										
14. FATHER'S NAME FIRST MIDDLE LAST John Sherman Biggs					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florea Katherine Arnett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 677-01-3256		17. INFORMANT ADDRESS Lillian F. Biggs same as 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 5188 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic lung disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident; Bacterial Endocarditis</u>														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>81</u> , to <u>June 3</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
23a. SIGNATURE <u>Elizabeth Anne Spitzer</u> MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-4-83						
23b. PHYSICIAN'S NAME (TYPE OR PRINT) Elizabeth Anne Spitzer, M.D.						22d. ADDRESS Owings, Maryland 20736								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 6/4/83		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia								
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt, Bx 34-B, Port Republic, Md.						25a. DATE REC'D. BY REGISTRAR 20676 JUN 8 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>						



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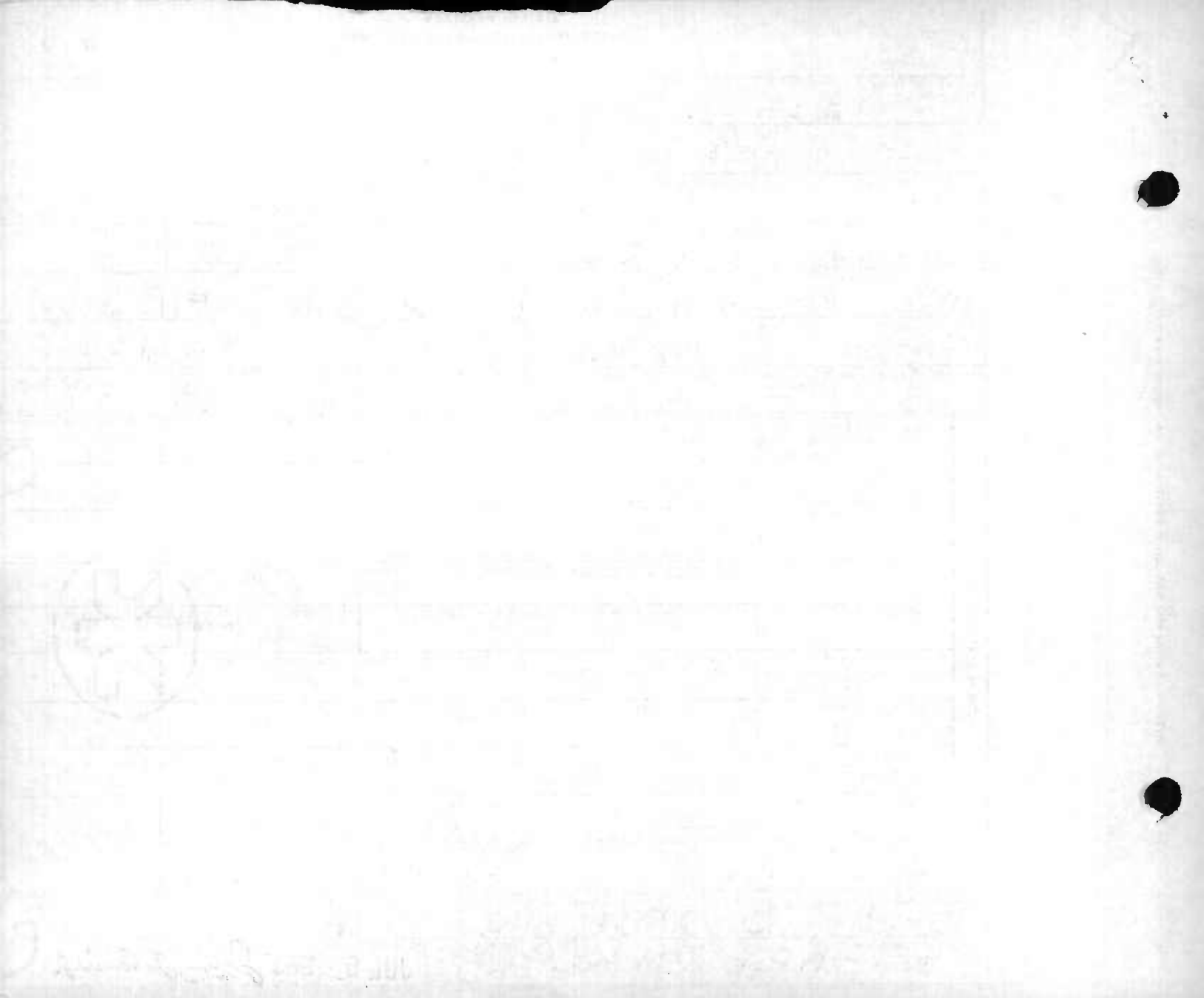
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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paulene M. Dalrymple			2a. DATE OF DEATH MONTH DAY YEAR June 29, 1983			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 7, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.			
10. CITY OR TOWN OF DEATH Price Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 49a Clay Hammond Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY Calvert		13c. CITY OR TOWN Price Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Grover Marks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby -unk-			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 462285860			17. INFORMANT ADDRESS James P Dalrymple Box 86f Price Frederick						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>cardiovascular arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung cancer.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from <u>June 1983</u> to <u>June 1983</u> , that (ii) we lost saw the deceased alive on <u>June 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) (did not) view the body after death.									22c. DATE SIGNED 7/1/83
22b. SIGNATURE <u>Ronald J. Ross</u> MD			DEGREE			ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22d. ADDRESS Price Frederick MD 20678	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald J. Ross			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 2, 1983		23c. NAME OF CEMETERY OR CREMATORY Wesley		23d. LOCATION CITY OR TOWN COUNTY STATE Price Frederick Cal MD		
24. FUNERAL DIRECTOR NAME Rausch Funeral Home MD			25. DATE REC'D. BY REGISTRAR JUL 6 1983			25. REGISTRAR'S SIGNATURE John J. Lauer			



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 3 1 6 0 6 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jennie Lyons DORSEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 6, 1983</b>			2b. HOUR <b>3:00P<sub>M</sub></b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 28 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Calvert</b> MD.			
10. CITY OR TOWN OF DEATH <b>Prince Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Calvert Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Calvert Dunkirk</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rural 20254</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph T Lyons</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>herenia Harrison</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>21322 0103</b>		17. INFORMANT ADDRESS <b>10330 Three Bunkers MD 20254</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>STROKE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>2 WEEKS</b> <b>2 WEEKS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NONE</b>							
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>MAY 19 83</b> to <b>6/6 19 83</b> that (I) (we) lost saw the deceased alive on <b>6/6 19 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <b>Elizabeth Ross</b>				DEGREE <b>—</b>		22b. DATE SIGNED <b>6/6/83</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elizabeth Ross, M.D.</b>				22e. ADDRESS <b>Prince Frederick, Maryland 20678</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 8, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyattsville MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Kawach Funeral Home MD</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1983</b>			

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BP

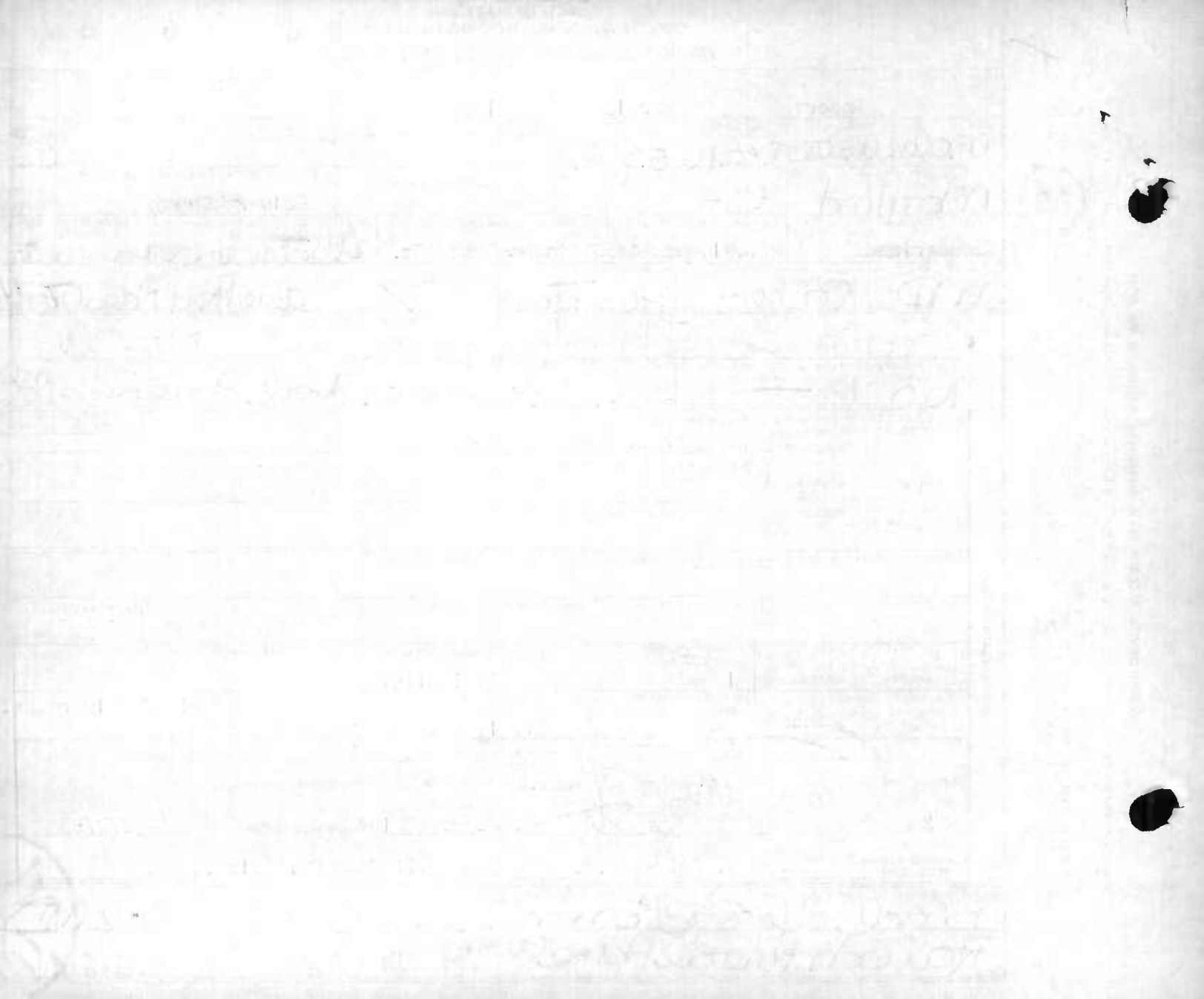


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16067	
1. DECEASED NAME (TYPE OR PRINT) <b>Robert Harold Gibson</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 6 19 83</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH (MONTH DAY YEAR) <b>Dec 16 55</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>27</b> RS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Calvert County, MD.</b>										2b. HOUR <b>M</b>	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 1, Box 6435 Stephen Reed Rd.</b>										2c. DATE PRONOUNCED DEAD <b>6 6 19 83</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>										2d. HOUR <b>1:45P</b>	
13a. STATE <b>MD</b> 13b. COUNTY <b>Calvert</b> 13c. CITY OR TOWN <b>Huntingtown</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Stephen Reed Rd 20857</b>											
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Harold L Gibson</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Verna L Russell</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> 16b. SOCIAL SECURITY NO. <b>012665083</b> 17. INFORMANT <b>hinae O'Neil Anne Fredrick</b> ADDRESS <b>MD</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound of chest</b> 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY <b>BODY ONLY</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY (HOUR MONTH DAY YEAR) <b>1 P.M. 6 6 19 83</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>self inflicted</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>	
21f. LOCATION (CITY OR TOWN, STATE) <b>Sunderland, Calvert, Md.</b>										21g. LOCATION (STREET) <b>Rt. 1, Box 6435 Stephen Reed Rd.</b>	
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Thomas D. Smith</b> TITLE (SPECIFY) <b>Deputy Chief</b> MEDICAL EXAMINER										DATE SIGNED <b>6/7/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b> ADDRESS <b>111 Penn St. Balto., MD.</b>											
23a. BURIAL CREMATION REMOVAL <b>Burial</b> 23b. DATE <b>6-8-83</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Rose-Maryboro O'wings</b> 23d. LOCATION (CITY OR TOWN, STATE) <b>MD</b>											
24. FUNERAL DIRECTOR <b>Rauch Funeral Home</b> ADDRESS <b>Owings</b> 25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Carish</b>											





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BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 6 0 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas William GRAY			2a. DATE OF DEATH MONTH DAY YEAR June 4, 1983			2b. HOUR P M 6:30 P			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Aug. 18 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.			
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Owings		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS Box 127		13f. STREET ADDRESS 20736							
14. FATHER'S NAME FIRST MIDDLE LAST Russell R. Gray			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Bowie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW-2			16b. SOCIAL SECURITY NO. 218-12-9472		17. INFORMANT ADDRESS Hazel Gray Box 127, Owings, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant</u> <u>1889</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the Bladder</u> DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 4-21-83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the Bladder			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>83</u> to <u>June</u> 19 <u>83</u> , that (I) (we) lost saw the deceased <u>June 4</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Modesto Shuein						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Modesto Rivera, M.D.						22e. ADDRESS Prince Frederick, Maryland 20678			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 10-83		23c. NAME OF CEMETERY OR CREMATORY Coopers Chr. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk Calvert Md		
24. FUNERAL DIRECTOR NAME Spencer E. Sewell						24b. ADDRESS Box 31, Prince Frederick, Md			
25a. DATE REC'D. BY REGISTRAR JUN 9 1983						25b. REGISTRAR'S SIGNATURE [Signature]			

Spencer S. Swain, Box 91, Prince Frederick, Md.

Serial June 10-83 Cooper's Gun, Rem.

Serial July 10-83

Serial 10-83

Serial 10-83

Serial 10-83

Serial 10-83

Serial 10-83

Serial 10-83

Serial 10-83

Serial 10-83

Serial 10-83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 6 0 6 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie Gertrude GRIERSON			2a. DATE OF DEATH MONTH DAY YEAR June 15, 1983		2b. HOUR 11:27 A.M.
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 23 1916	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.		
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY —	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Calvert	13c. CITY OR TOWN Dwings	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 5th Street 20736	
14. FATHER'S NAME FIRST MIDDLE LAST Nobel Dobson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Cox			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 21544 4438	17. INFORMANT ADDRESS Herbert R Grierson Box 334 Dwings MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3352 RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) AMYOTROPHIC LATERAL SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-12 19 83, to 6-15 19 83, that (I) (we) last saw the deceased alive on 6-15 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. H. Weigel		DEGREE M.D.		22c. DATE SIGNED 6-15-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Weigel, M.D.		22e. ADDRESS Prince Frederick, Maryland 20678			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 18, 1983	23c. NAME OF CEMETERY OR CREMATORY St. Harmony Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dwings Calvert MD
24. FUNERAL DIRECTOR Name Nauoch Funeral Home		Address Dwings MD		25. ISSUED BY REGISTRAR JUN 22 1983	

The first part of the report is a summary of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The second part of the report is a detailed account of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The third part of the report is a summary of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The fourth part of the report is a detailed account of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The fifth part of the report is a summary of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The sixth part of the report is a detailed account of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The seventh part of the report is a summary of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The eighth part of the report is a detailed account of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The ninth part of the report is a summary of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced. The tenth part of the report is a detailed account of the work done during the year. This includes a description of the projects completed, the results achieved, and the challenges faced.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 6 0 7 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys NMN HICKS				2a. DATE OF DEATH MONTH DAY YEAR June 10, 1983		2b. HOUR 6:40 P	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR May 08 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.	
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Owings		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Hicks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Holland		13e. STREET ADDRESS Box 90 Clyde Jones Rd. 20736			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-38-7173		17. INFORMANT ADDRESS Pearl Jones Box 90 Clyde Jones Rd., Owings			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5850 IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UREMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC RENAL FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>YRS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>N/A</u>							
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> , 19 <u>83</u> , to <u>6/10</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>6/10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING MEDICAL <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/11/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. ROSS</u>		22e. ADDRESS <u>Box 262C P.R. FARM, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 16-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Chr. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sunderland Calvert Md	
24. FUNERAL DIRECTOR NAME Spencer E. Sewell				ADDRESS Box 31, Prince Frederick, Md		25a. DATE REC'D. BY REGISTRAR JUN 14 1983	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

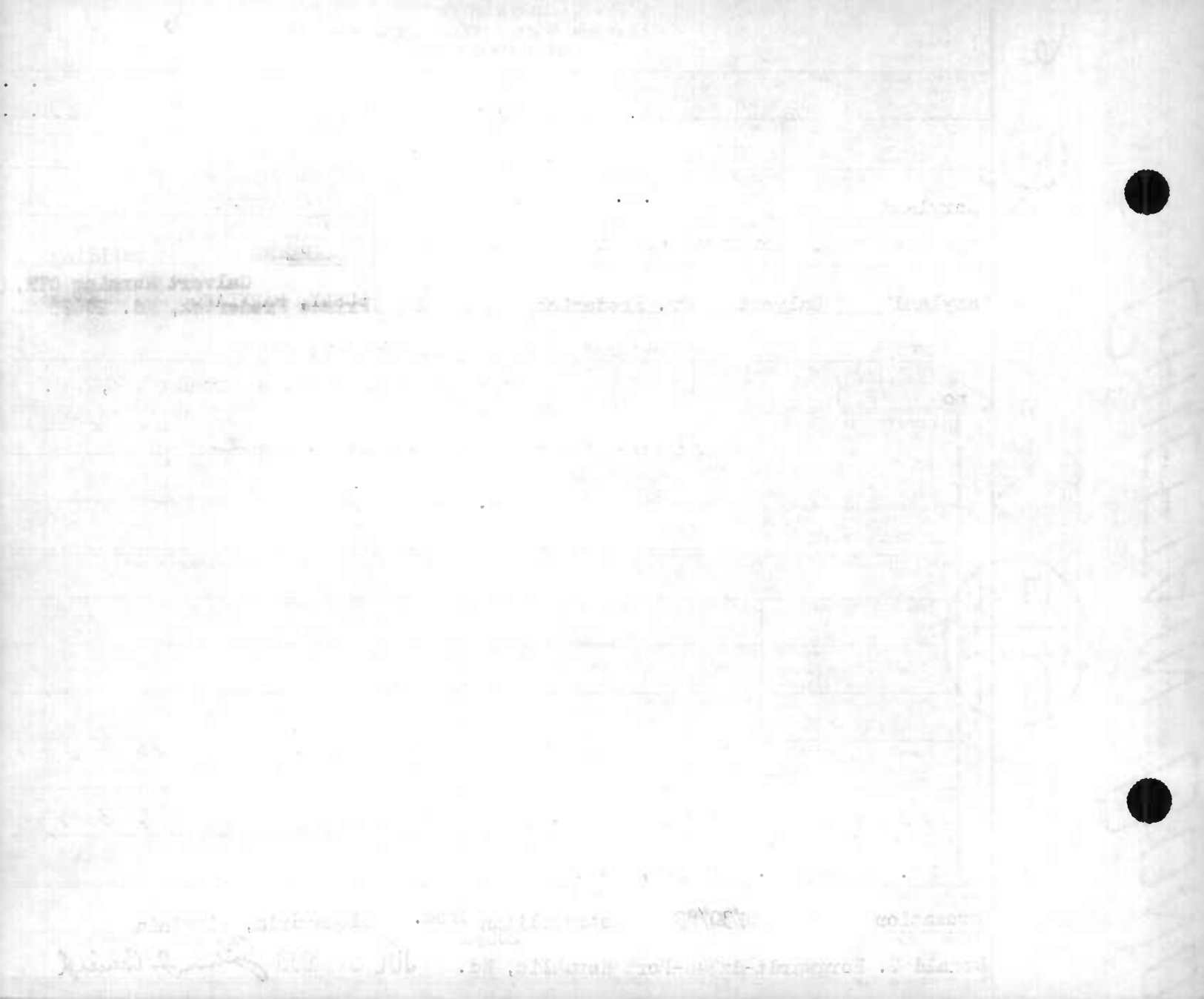
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 6 0 7 1			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <b>Joseph N. Johnson</b>				MONTH DAY YEAR <b>6 30 83</b>			
3 SEX				2b. HOUR a.m. p.m.			
<b>Male</b>				<b>1 30 p.m.</b>			
4. RACE				5. DATE OF BIRTH			
<b>White</b>				MONTH DAY YEAR <b>11 3 02</b>			
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
<b>Maryland</b>				<b>U.S.</b>			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
<b>Prince Fred.</b>				<b>Calvert County Nursing Center</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
<b>CARPENTER</b>				<b>building</b>			
13a. STATE				13b. CITY OR TOWN			
<b>Maryland</b>				<b>Calvert</b>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST <b>Joseph E. Johnson</b>				FIRST MIDDLE LAST <b>Ida Kellum Johnson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
<b>no</b>				<b>216058392</b>			
17. INFORMANT				ADDRESS			
<b>Carl Johnson</b>				<b>Prince Frederick, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4292 IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>83</u> , to <u>6-30</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>6-22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<b>Ronald E. Thomas</b>				<b>M.D.</b>		<b>6-30-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
<b>Dr. Ronald E. Thomas, M.D.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<b>cremation</b>				<b>6/30/83</b>		<b>Metropolitan Crem.</b>	
24. FUNERAL DIRECTOR				23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
NAME ADDRESS <b>Donald V. Borgwardt-Bx34B-Port Republic, Md.</b>				<b>20676 Alexandria, Virginia</b>		<b>JUL 5 1983</b>	
25a. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE			
<b>JUL 5 1983</b>				<b>John J. Conner</b>			

BP







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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5  
1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

1 6 0 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Myrtle Bowen LIST			2a. DATE OF DEATH MONTH DAY YEAR June 28, 1983			2b. HOUR 9:00 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 - 23 - 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.				
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Sewing		
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 420 Dares Bch Rd. Apt. 312, Prince Frederick, Md.		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bowen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Weisman				20678		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-01-9622		17. INFORMANT 4548 Lewiston St. Jo Ann Rakes Roanoke, Virginia 20417				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) <i>Melanoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cx of Breast with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastases</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>hmc</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>June 28 83</i> to <i>June 28 83</i> , that (I) (we) lost <i>the deceased alive on</i> <i>June 28 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.										
22b. SIGNATURE <i>R. de Villard</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>June 29/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. de Villard</i>			22e. ADDRESS <i>St Leonard, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/1/83		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie-A.A. Md.			
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt-Bx 34B, Port Republic, Md. 20676					25a. DATE REC'D. BY REGISTRAR JUL 5 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Gair</i>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

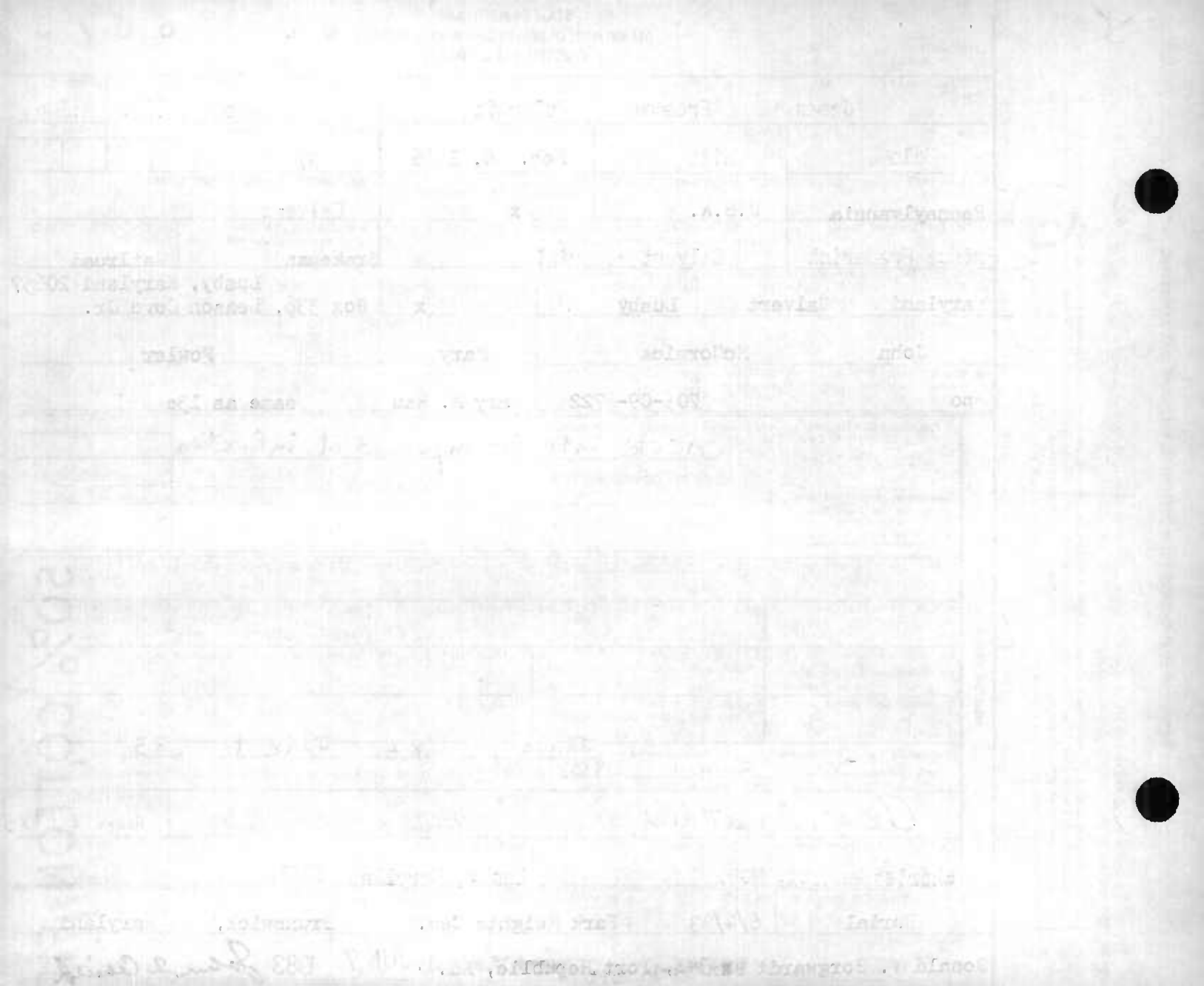
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 6 0 7 3			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST James Freeman McCormick				MONTH DAY YEAR June 1 1983			
3. SEX Male				2b. HOUR 9:30p <sub>M</sub>			
4. RACE White				6. AGE (IN YEARS LAST BIRTHDAY)			
5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1886				7. BALTIMORE CITY OR COUNTY OF DEATH Calvert			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
7b. CITIZEN OF WHAT COUNTRY? U.S.A.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman			
10. CITY OR TOWN OF DEATH Prince Frederick				12b. KIND OF BUSINESS OR INDUSTRY Railroad			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial				13a. STREET ADDRESS Lusby, Maryland 20657 Box 336, Leason Cove Dr.			
13a. STATE Maryland				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13c. COUNTY Calvert				13d. CITY OR TOWN Lusby			
14. FATHER'S NAME FIRST MIDDLE LAST John McCormick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Fowler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 705-09-6722			
17. INFORMANT Mary M. Rau				ADDRESS same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute inferior myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>January 19, 82</u> , to <u>June 1, 83</u> , that (I) (we) lost saw the deceased alive on <u>June 1, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles Bennett M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 2, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Bennett, M.D.				22e. ADDRESS Lusby, Maryland 20657			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/83		23c. NAME OF CEMETERY OR CREMATORY Park Heights Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brunswick, Maryland	
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt				25a. DATE REC'D. BY REGISTRAR JUN 7 1983			
				25b. REGISTRAR'S SIGNATURE John J. Carver			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8316074			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leonard Henderson QUERRY				2a. DATE OF DEATH MONTH DAY YEAR June 9 1983				2b. HOUR 6:45P M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 5 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.					
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Mechanic		12b. KIND OF BUSINESS OR INDUSTRY repair			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Calvert 13c. CITY OR TOWN Chesapeake Beach				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3921 13th Street 20732					
14. FATHER'S NAME FIRST MIDDLE LAST William P. Querry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie E. Christenbury				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN NO			
(IF YES, GIVE WAR OR DATES) N/A				16b. SOCIAL SECURITY NO. 577 10 0024A		17. INFORMANT Elizabeth Jacobs				30645 Brinkly Rd. Apt. 201 Temple Hills, Maryland	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4413 CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED ANEURYSM OF Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) ABDOMINAL AORTA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. COPD Neurogenic Bladder Cerebrovascula Dis											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/31/83 to 6/13/83, that (I) (we) lost the deceased alive on 6/9/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE AT Munshi				DEGREE MD				ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/10/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar Munshi, M.D.				22e. ADDRESS Prince Frederick, MD. 20678							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE June 13, 1982		23c. NAME OF CEMETERY OR CREMATORY Southern Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk Calvert Md			
24. FUNERAL DIRECTOR NAME Rausch Funeral Home Owings Maryland				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 15 1983 John J. Connel							

BP

20% COTTON

DIFFERENTIAL



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8316075

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Calvert Maryland RAY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 24, 1983</b>		2b. HOUR <b>6:43A</b>
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 08, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Calvert</b> MD.	
10. CITY OR TOWN OF DEATH <b>Prince Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Calvert Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Calvert</b>	13c. CITY OR TOWN <b>Huntingtown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Ray</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anella Morsell</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-03-4290</b>		17. INFORMANT NAME ADDRESS <b>Josephine Ray Rt. 1 Box 387 Huntingtown, MD 20639</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic esophageal cancer.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22/83</u> 19 <u>83</u> , to <u>6/24</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>6/23/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			
22b. SIGNATURE <u>Ronald Ross</u>		22c. DATE SIGNED <u>6/24/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Ross, M.D.</b>		22e. ADDRESS <b>Prince Frederick, Maryland 20678</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>June 29, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Church Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sunderland Calvert Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Mr. Spencer E. Sewell Box 31 Prince Fred. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1983</b>	
		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	



30% COTTON FIBRE

THE LANCET



Mr. Spencer E. Bennett Box 31 Prince Fred, Md.  
June 29, 1963 Re: Robertson Cemetery, Calverton, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 16076			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George E. Smith				June - 17 - 83 120 AM			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 5 18 03		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Calvert County MD.	
10 CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Co. Nursing Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Huntingtown		13e. STREET ADDRESS Box 67, Huntingtown Rd. 20639	
14 FATHER'S NAME FIRST MIDDLE LAST William Smith				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Coates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-12-9821		17 INFORMANT ADDRESS Box 67 Huntingtown Gladys Elizabeth Smith			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				Box 67, Huntingtown, Md			
IMMEDIATE CAUSE (a) 1719 Cardiorespiratory arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic leiomyosarcoma.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6 19 82 to 6/16 19 83, that (I) (we) lost saw the deceased alive 5:45-6:15 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE				22c. DATE SIGNED 6-17-93			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald J. Ross Jr. MD.				22e. ADDRESS Prince Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 22-83		23c. NAME OF CEMETERY OR CREMATORY Youngs Chr. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Huntingtown Calvert Md.	
24. FUNERAL DIRECTOR NAME Spencer E. Sewell				ADDRESS Box 31, Prince Frederick, Md		25a. DATE REC'D. BY REGISTRAR JUN 23 1983	
				REGISTRAR'S SIGNATURE [Signature]			

DATE RECEIVED  
JUN 25 1967  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

100-100000

TO: DIRECTOR, FBI (100-100000) FROM: SAC, NEW YORK (100-100000) SUBJECT: [illegible]

RE: [illegible]

100-100000

100-100000-100000  
JUN 25 1967  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

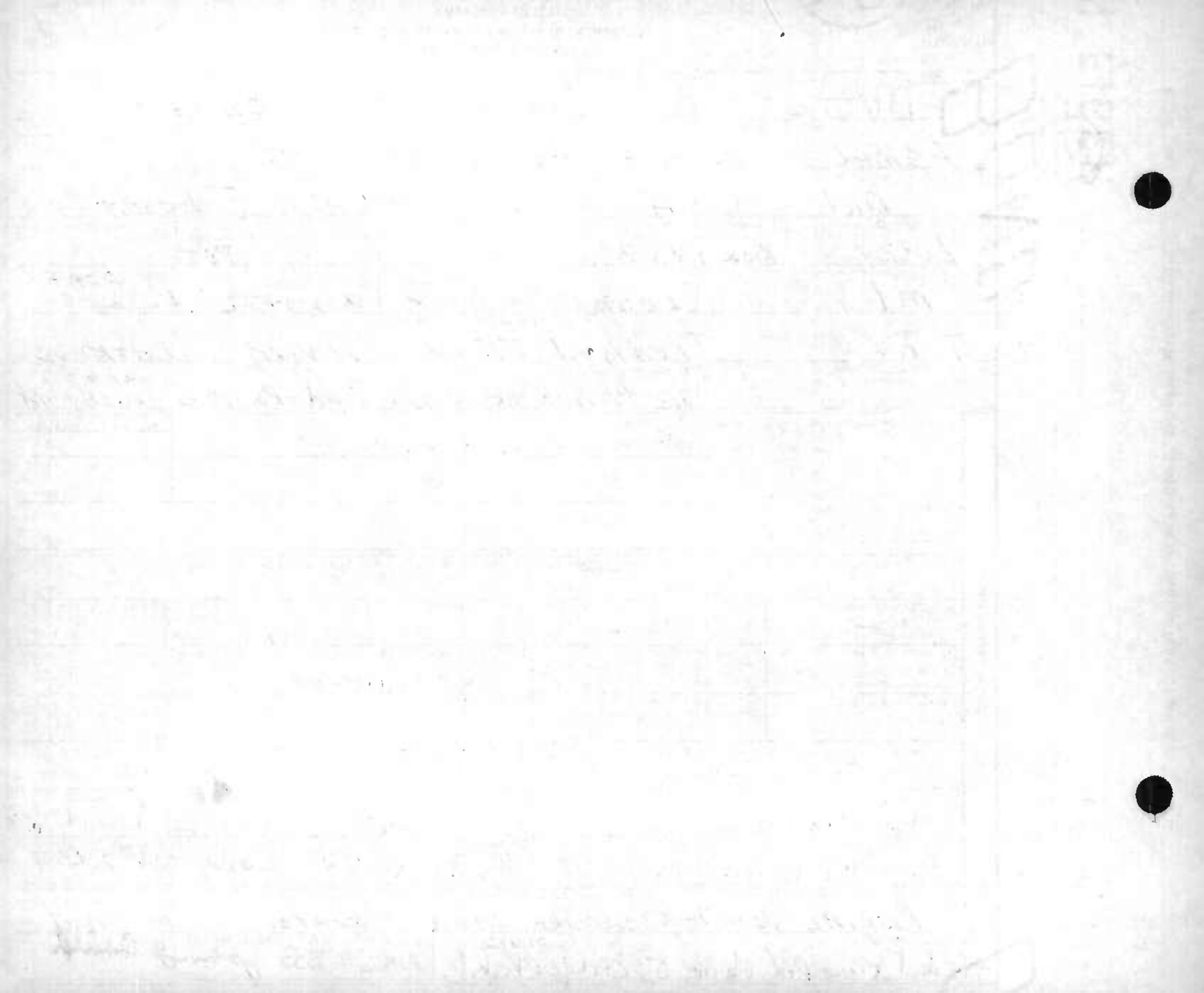
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										83	16077
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>MATTIE R. Smith</b>					2a. DATE OF DEATH MONTH <b>06</b> DAY <b>14</b> YEAR <b>83</b>			2b. HOUR <b>M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>03</b> DAY <b>22</b> YEAR <b>1885</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>98</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CALVERT LUSBY CO MD.</b>					
10. CITY OR TOWN OF DEATH <b>LUSBY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Box 143 B</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>md.</b>			13b. COUNTY <b>CALVERT</b>		13c. CITY OR TOWN <b>LUSBY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 143 B, Lusby 20657</b>		
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b></b> LAST <b>TRELAND</b>				15. MOTHER'S MAIDEN NAME FIRST <b>JEAN</b> MIDDLE <b>ANNA</b> LAST <b>LUATKINS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-54-1903</b>		17. INFORMANT ADDRESS <b>MRS. Gladys Byrd - Bx 143 B - Lusby, Md. 20657</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>											
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Not applicable</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>November 11, 1982</b> to <b>June 14, 1983</b> , that (I) (we) lost saw the deceased alive on <b>June 6, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles Bennett M.D.</b> DEGREE <b>M.D.</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>June 14, 1983</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Bennett M.D.</b>						22e. ADDRESS <b>Box 88, Route 4 Lusby, Md. 20657</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6-17-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western STAR</b>			23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>md.</b> STATE <b>md.</b>			
24. FUNERAL DIRECTOR NAME <b>Redd Funeral Home</b> ADDRESS <b>5209 York Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA JANE SOUTHARD					2a. DATE OF DEATH MONTH DAY YEAR June 2 1983			2b. HOUR 9:20 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 28 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.			
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Accounting	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. CITY MD Calvert					13c. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		13d. STREET ADDRESS 8216 Bayside Rd 20230		
14. FATHER'S NAME FIRST MIDDLE LAST John B Gongaware					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L Ketz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 57801214		17. INFORMANT Curtis Southard Jr		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic / Renal Failure 5714 DUE TO, OR AS A CONSEQUENCE OF, (b) Liver Cirrhosis - Cryptogenic DUE TO, OR AS A CONSEQUENCE OF, (c) Chronic Hepatitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-1a-83									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Renal failure / Portal Hypertension / GI Bleeding									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/21/83, 19 to 6-2-1983, that (I) (we) last saw the deceased alive on 6-2-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Zahir Yousaf					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Zahir Yousaf, M.D.					22e. ADDRESS Prince Frederick, MD 20678				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-7-83		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Fairfax VA			
24. FUNERAL DIRECTOR NAME Hausech Funeral Home		ADDRESS MD		25a. DATE REC'D. BY REGISTRAR JUN 10 1983					
25b. REGISTRAR'S SIGNATURE John J. Lauer									

